

TennCare Program Design and Waiver Modifications

**State of Tennessee
Don Sundquist, Governor**

**Submitted to:
Secretary Tommy Thompson
Department of Health and Human Services**

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I. Executive Summary

I. EXECUTIVE SUMMARY

Introduction

Tennessee has operated its Title XIX Medicaid program under a Section 1115 waiver since January of 1994. The entire Medicaid budget is subject to a global federal cap. However, some services, like long-term care, are still provided pursuant to the Medicaid State Plan. It is the managed care portion of the program that is the subject of these proposed modifications.

A Brief Program History of the Managed Care Program

The TennCare program began in January 1994 as the broadest, most comprehensive Medicaid Section 1115 waiver demonstration program ever attempted. The General Assembly joined Governor Ned McWherter in this undertaking to provide access to “affordable comprehensive health care coverage for virtually every Tennessean.” The state believed that enrolling the entire Medicaid population into a managed care environment would produce significant savings. And with those savings, the state would offer coverage to Tennesseans without access to employer-sponsored health insurance. The federal government agreed to provide Federal Financial Participation (FFP) for authorized program expenditures as long as the total five-year expenditures remained within the parameters established at the outset for budget neutrality and the state met the other terms and conditions of the project.

Tennessee’s program was approved with a global budget cap that included enrollee premium collections as matching state funds and matching federal funds for certified public expenditures. The all-encompassing scope of the global budget and the negotiated terms for financial participation have been critical to the success of the TennCare program.

The state began TennCare with such enrollment success that Governor McWherter announced in December 1994 that enrollment to the uninsured population would be temporarily closed effective January 1995. For budgeting purposes, the state had imposed an enrollment cap of 1.5 million enrollees on the program. The program remained open to Medicaid-eligible individuals and to individuals with proof of uninsurability.

The state moved its behavioral health services into a managed care environment in July 1996 and began the TennCare Partners Program. In April 1997, TennCare for Children began and was subsequently expanded in January 1998. The TennCare for Children program assured access to health insurance for every child in Tennessee. Also, the TennCare program was expanded by the

efforts of the General Assembly to provide access to health insurance coverage to certain dislocated workers.

Services to enrollees were provided by health maintenance organizations known as managed care organizations (MCOs) and behavioral health organizations known as BHOs. Enrollees had a choice of MCOs, as well as a choice of providers from the MCO networks. Since MCOs and BHOs were linked, enrollees' choice of BHOs was determined according to the MCO they picked. They had a choice of providers from the BHO networks as well. Enrollees with family incomes above the poverty level who were not Medicaid eligible paid premiums and cost sharing on a sliding scale basis.

Individuals originally were eligible for TennCare if they were Medicaid-eligible, uninsurable, or did not have access to employer-sponsored health insurance or to COBRA coverage. All of the non-Medicaid eligible groups are referred to collectively as the "expansion population" or the "demonstration population."

TennCare Successes

TennCare has improved access to health insurance for Tennesseans and, at the same time, saved money. The Center for Business and Economic Research at the University of Tennessee conducts an annual survey of Tennessee residents in order to ascertain their insurance status, use of medical facilities, and satisfaction with the TennCare Program. The base year for the survey is 1993. The uninsured rate for Tennessee that year was 8.9 percent. The 2001 survey, the one most recently completed, indicated that there are approximately 353,736 uninsured individuals, representing 6.22 percent of the 2001 population.

Additionally, in a reflection of the policies implemented by the state in 1997 and 1998, Tennessee has made progress in providing insurance for children under 19 years of age. The uninsured rate for children under 18 is 4.01 percent.

All in all, TennCare has provided quality health care coverage to over 400,000 people who would not otherwise have health insurance.

Overall health care indicators have also improved as a result of the TennCare program. In 1993, the percentage of TennCare 24 month old children who were completely immunized was 66 percent; in 2000, that number had risen to 86.5 percent. Infant mortality rates are down, use of emergency room services for primary care is down, and treatment for pediatric asthma is resulting in fewer hospital days, emergency admissions and more regular doctors' office visits.

In the 2001 survey, 79 percent of the respondents expressed satisfaction with TennCare. This pattern has been stable since 1996. Respondents also continue

to perceive that the quality of the care they receive through the program is good, especially for children.

TennCare has saved the federal government significant money, even considering that federal participation has declined from a high of 73.5% in Federal Fiscal Year 1996 to 66.4% in 2001, the most recent fiscal year. The state has spent \$734 million less in federal funds than it was authorized to spend; and Tennessee has not spent \$227 million of its federal State Children's Health Insurance Program (SCHIP) allotment. TennCare's average annual per member cost (\$2859) is the lowest of any of the southern states, according to the Southern Legislative Conference.

Current Status of the Program

As of June 30, 2001, TennCare was providing health care coverage for 1.45 million Tennesseans. Currently, nine Managed Care Organizations (MCOs) and two Behavioral Health Organizations (BHOs) provide services to enrollees. For MCOs, the state has moved towards a regional system of service delivery rather than having them operate statewide. The BHOs operate statewide. The state has established its own plan, TennCare Select, that operates as a plan whose risk is backed by the state. At present, this plan, which is currently managed by Blue Cross Blue Shield of Tennessee, provides services to children in state custody, SSI children, children receiving long term care services, certain individuals whose eligibility status is being reviewed, and enrollees who are residents temporarily living out of state. The plan also operates as a statewide "safety net" plan should any other of the MCOs fail. Behavioral health services to those enrolled in TennCare Select are provided by one of the BHOs.

In October 2001, the state sought an extension of the current program for a period of three years. The extension was sought to ensure that there would be no disruption in the program or in coverage to enrollees as the state prepared its requested modifications and planned for an orderly transition to the next generation TennCare program.

It is undeniable that the TennCare program has had extraordinary successes in controlling costs, extending health care to uninsured people in Tennessee, and promoting preventive care. These gains notwithstanding, however, TennCare must change if it is to continue to reach its original goals. TennCare has operated within a highly charged atmosphere of public interest and debate. We have learned a great deal in the past eight years about what is workable and achievable within this atmosphere. The revisions in the program design, which are described in the following pages, are being proposed with this new knowledge in mind.

The Future of TennCare

While the TennCare program has been successful in both increasing access to health insurance for individuals who would otherwise have none and in controlling state and federal costs, the program has not been without its critics. In anticipation of the end of the program's three-year extension under the terms of the Balanced Budget Act (BBA), the Governor convened a statewide Summit on the Future of TennCare and appointed a Commission on the Future of TennCare to review the program and make recommendations about its future. The Commission began its work in February 2000. The Commission held numerous open meetings and devoted some of those specifically to hearing from representative stakeholder groups. The Commission reported to the Governor and the General Assembly in November 2000. Subsequently, the Governor had public meetings held in 10 locations across the state in order to receive public comment on the Commission's recommendations. In addition, the public had the opportunity to review materials via the TennCare website and were invited to provide written comments on the proposed changes.

After studying the recommendations from the Commission and the comments received from the General Assembly, stakeholders and the general public prior to, during, and following the Commission's deliberations, the Governor directed the development of a proposal to modify the current Section 1115 demonstration waiver. These proposed modifications are described in this document.

Guiding Principles

Several guiding principles, many of which were recommended by the Commission on the Future of TennCare, have been selected for the proposed waiver modifications. These principles are that TennCare should:

- be the health insurance program of last resort for Tennesseans;
- ensure that Tennessee children have access to health insurance coverage;
- cover as many Tennesseans in need as can be done in a fiscally responsible manner;
- promote individual responsibility and accountability;
- make enrollment prospective;
- encourage use of employer-sponsored coverage;
- provide coverage for beneficiaries in the expanded population that is generally comparable to private-sector basic HMO coverage;
- maintain and maximize federal funding within the overall construct of a managed care program;
- maintain the program in an actuarially sound manner;
- compensate providers reasonably and promptly, within the context of a publicly funded program; and

- work to improve the overall health status of Tennesseans.

TennCare Design Proposal

The modified TennCare program is proposed to be a managed care program for both the Medicaid population and the expansion population. It will have three distinct products and will include six distinct eligibility categories, two of which are Medicaid and the remainder of which are demonstration eligibles. These categories are illustrated in the table on the following page.

Eligibility Groups in the Modified Waiver

TennCare Program	Eligibility Group	Description
TennCare Medicaid	Group A	Tennessee residents who have been determined eligible for Medicaid.
	Group B	Tennessee women who are uninsured, who are under age 65, and who have been determined through the Centers for Disease Control to need treatment for breast or cervical cancer.
TennCare Standard	Group C	Tennessee residents who are uninsured, who do not have access to group health insurance, and who have incomes below 250 percent of poverty*.
	Group D	Tennessee residents at any income level* who are uninsured and who are determined to be "medically eligible" by a state contracted medical underwriter. <i>Application fee required.</i>
	Group E	Tennessee residents at any income level who were enrolled in TennCare as of December 31, 2001, with Medicare but not Medicaid coverage, and who continue to meet the criteria for "Uninsurable" status in place at that time. <i>These individuals will only be eligible for the TennCare Standard pharmacy benefit package.</i>
	Group F	Tennessee residents who were enrolled as Uninsured children in TennCare as of December 31, 2001, even if they had access to insurance, because their family incomes were below 200% poverty and who continue to meet the criteria of being under the age of 19 and with family incomes below 200% poverty. <i>This group will move to TennCare Assist at such time as TennCare Assist becomes available.</i>
TennCare Assist	Group G	Tennessee residents with incomes below 250 percent of poverty* who are employed, who have access to employer-sponsored health insurance, whose employer provides at least a standard HMO benefit package with out-of-pocket expenditures that do not exceed \$2,000 for an individual or \$4,000 for a family, and whose employer contributes at least 60 percent of the premium.

**NOTE: Income levels are subject to revision downward, depending upon the funding level determined by the General Assembly and the availability of funds within the federal budget neutrality cap.*

Group A eligibles are those who meet current Medicaid eligibility requirements. **Group B** is a proposed new Medicaid eligibility category. **Groups C, D, E, F, and G** are the demonstration populations for the proposed modified TennCare waiver.

Tennessee residents who are eligible for Medicaid will, of course, be allowed to enroll in TennCare at any time. Current demonstration enrollees who meet the criteria for TennCare Standard, including the income criteria in effect at the time that TennCare Standard begins, will move from TennCare into TennCare Standard on the date the new program is implemented. They will not experience a break in coverage, although they may experience some reductions in the overall benefit package since TennCare Standard benefits are not as extensive as those in TennCare Medicaid.

For new demonstration eligibles who are not currently enrolled in TennCare, the state wishes to maintain flexibility in its enrollment practices to insure that individuals are added to the program only when sufficient funds have been appropriated by the General Assembly and there is availability of funds under the federal budget neutrality cap. The two points on which we wish to be flexible are time of enrollment and income levels.

- Enrollment periods. We anticipate holding up to two fixed enrollment periods per year for demonstration eligibles and, in addition, we want to leave open the option of allowing continuous enrollment for those medically eligibles (Group D, see page 9) who have incomes no greater than poverty. Administrative flexibility in establishing the timing and scope of enrollment is critical to the state's ability to properly manage the program within appropriations from the General Assembly and the federal budget neutrality cap. All open and continuous enrollment periods will, of course, be preceded by appropriate notice.
- Income levels. We will set income thresholds for the demonstration population only when the General Assembly has decided upon available funding levels. The maximum income threshold to be used for Groups C and G (see page 9) of the demonstration population will be 250 percent of poverty, since 200 to 250 percent of poverty is an income level range that is fairly consistent with income thresholds used by other federal programs. The income level for TennCare Standard may be lower, however, depending upon the availability of funds. The state retains the discretion to set different income levels for children and adults within the overall maximum income threshold.

Services for TennCare Medicaid and TennCare Standard will be provided through managed care contractors operating in one of three grand regions of the state. Each grand region will have at least two contractors available. The state intends to work with its contractors toward reaching a minimum of 100,000 lives

and a maximum of 300,000 enrollees, and plan enrollment will be managed so that the ceiling will not be reached. Pharmacy services for the TennCare/Medicare enrollees in TennCare Standard (Group E, see page 9) would be provided either through the state's TennCare Select plan or through the state's pharmacy program.

All TennCare MCOs will be expected to provide two benefit packages—one for TennCare Medicaid and one for TennCare Standard. TennCare Medicaid members will receive most of the current array of Medicaid benefits. TennCare Standard members will have a benefit package that is generally comparable to private sector basic HMO coverage and the coverage currently afforded Tennessee state employees.

TennCare Medicaid and TennCare Standard members will receive their behavioral health and substance abuse benefits through a TennCare Partners' behavioral health organization. Physical health pharmacy benefits will be provided to both programs through their managed care organization. Behavioral health pharmacy benefits for both groups will be provided through the state pharmacy benefits program. Dental benefits will be provided through a Dental Benefits Manager (DBM). Children in TennCare Standard will be offered an option to purchase, at their cost, a separate dental benefits package from the DBM.

All TennCare Standard members with incomes above the poverty level will have cost-sharing responsibilities. Premiums will be based on income and will be on a sliding scale. There will also be copays for this group for a variety of the services. However, to promote healthy habits, there will be no copay requirements for preventive care visits, such as well child visits, immunizations, adult physicals, pap smears, prostate examinations, and mammograms. There will be a copay requirement for all other doctors' visits, hospital stays, emergency room visits, and prescription drugs. The prescription drug copay will be less for generic drugs than brand name drugs (e.g., \$5 versus \$15). The emergency room visit copay will be higher than a doctor's office visit copay to encourage appropriate health care utilization. There will be no emergency room copay if the person is admitted.

TennCare Assist, when implemented, will provide services to individuals through their employer-sponsored health plan. TennCare Assist enrollees will receive their physical and behavioral health services and pharmacy benefits through their employer-sponsored health plan.

The specific modifications for eligibility and enrollment, benefit design and service delivery for the three TennCare products are all described in more detail in the following chapter.

II. Modified Program Design

II. MODIFIED PROGRAM DESIGN

A. TENNCARE MEDICAID

Eligibility

TennCare Medicaid will be available to all Tennessee residents who meet Medicaid requirements, including those individuals who are dually eligible for Medicaid and Medicare. These determinations continue to be made in accordance with the 1993 Medicaid State Plan. Medicaid eligibles, by federal definition, can have access to other insurance and still be eligible for the program.

In addition, the state will extend Medicaid eligibility to uninsured women under the age of 65 who have been determined to have breast or cervical cancer, including precancerous conditions, through the Centers for Disease Control screening process. Eligibility for this group will begin with presumptive eligibility and last until the course of treatment has ended.

Enrollment and Disenrollment

Individuals who are eligible for Medicaid through Supplemental Security Income (SSI) may apply at any time through the Social Security Administration. Individuals who are eligible for Medicaid through any other category may apply at any time through the Department of Human Services (DHS).

All TennCare Medicaid recipients qualify for eligibility as of the effective date of their application or qualifying event, whichever is later. For persons applying for Medicaid at DHS, there will be a change in how the “effective date of application” will be calculated. Currently, the “effective date of application” is the date a full application is completed at a DHS office. Under the modified program, if an individual or his/her representative needs to apply for Medicaid during a time when DHS offices are closed (weekends, evenings, holidays), he/she may fax an application to DHS at that time, and, if he/she follows up with a full application at DHS on the next business day for DHS, the “effective date of application” will be the date the faxed application was received by DHS.

Individuals meeting Medically Needy criteria are certified Medicaid eligible for 12 months of coverage. Individuals meeting other Medicaid criteria are certified eligible for a period as determined by DHS. TennCare Medicaid enrollees receive at least a 30-day notice prior to the end of their eligibility period. During this period, Medicaid enrollees may submit an application to TennCare Standard. To the extent the enrollee is eligible under the then-existing TennCare Standard requirements, the individual may be enrolled immediately into TennCare

Standard. Medicaid enrollees are thus given an opportunity to apply for TennCare Standard when they no longer qualify for TennCare Medicaid eligibility and, if they meet the TennCare Standard criteria then in place (including the income criteria), there will be no break in coverage.

Benefit Package

TennCare Medicaid enrollees will continue to receive the current benefit package under the proposed modifications with the exception that home health care visits will be limited to 125 visits per adult enrollee per calendar year. In addition, the following services are eliminated for adults: sitter services, adult cataract glasses, convalescent care and private duty nursing care. These changes would go into effect January 1, 2003. TennCare Medicaid enrollees will not be responsible for premiums or copays.

TennCare Medicaid enrollees will receive a full benefit package of behavioral health and substance abuse services. TennCare Partners benefits will be available to all participants to the extent they are medically necessary. The dollar and day limitation on the substance abuse benefit will not apply to Medicaid eligible children. (See Attachments A and B for the benefit packages for physical and behavioral health.)

Service Delivery (as described in Attachment D)

Following the guiding principles articulated for the TennCare program by the Commission on the Future of TennCare, the service delivery system will remain largely a managed care model. Since the design and implementation of TennCare II in 2000-2001, the state has focused on eliminating the dominance of any one MCO by moving to a regional system in which all participating MCOs must agree to provide services in at least one of the three grand regions in the state. The state has worked with its contractors to “right size” enrollment so that all TennCare MCOs will ultimately have a minimum enrollment of 100,000 and a maximum enrollment of 300,000. In addition, the state will continue to contract with a state-owned but privately administered TennCare Select plan that will provide services to selected populations and serve as a back-up plan for full-risk contractors who may need to be down-sized or eliminated from the program.

The TennCare Medicaid service delivery system will remain as it is in the current program. The TennCare Medicaid physical health benefit package generally will be delivered by contracted MCOs. The TennCare Medicaid behavioral health services will continue to be delivered by Behavioral Health Organizations and the behavioral pharmacy benefit will continue to be provided by the state through its pharmacy program. The state will consider the option of contracting with a single BHO, rather than multiple BHOs, for all covered mental health and substance

abuse services. Covered dental benefits will be provided through a dental benefits manager (DBM). Other Title XIX non-managed care services will continue to be provided to TennCare Medicaid eligibles through the various state programs currently in operation (ie: long term care, HCBS services, etc.). See Attachment D.

The only change from current practice for TennCare Medicaid is that the state wants to preserve the option of requiring that those individuals dually eligible for both Medicaid and Medicare will have their TennCare services, primarily prescription drugs, provided through the state's MCO, TennCare Select. If the state pursues that option, these individuals will not be given a choice of MCOs. In addition, the state is seeking a waiver authorizing it to assign these dually eligible individuals, as well as those in Group E (see page 9), to a specific primary care provider who will authorize and monitor the prescription drugs used by this group. (See Attachment D.)

B. TENNCARE STANDARD

Eligibility

TennCare Standard will be offered to two groups of Tennessee residents who do not have access to group health insurance:

- those who have incomes below 250 percent of poverty (Group C, see page 9); and
- those who are “medically eligible” at any income level. (Group D, see page 9.)

In addition, a third group will have access to pharmacy benefits only under TennCare Standard. This group will be persons enrolled in TennCare as of December 31, 2001, who have Medicare but not Medicaid, and who continue to meet the criteria for “Uninsurability.” (Group E, see page 9.).

A fourth group, also to be “grandfathered in” from the current program, will be children under 19 with family incomes below 200% poverty and access to insurance who were enrolled in TennCare as of December 31, 2001. (Group F, see page 9.) At such time as these children reach their 19th birthday and/or their family income exceeds 200% poverty, they will have to be eligible in another category in order to remain on TennCare. They will have premium and copay obligations if their family income exceeds 100% poverty. At the time that TennCare Assist becomes available, these children will move into that program if they qualify.

Depending upon appropriations from the General Assembly and the availability of funds within the federal budget neutrality cap, the state may authorize lower income levels than those stated above. However, at no time will the state extend coverage to persons in the demonstration population, other than “medically eligibles” and enrollees in Group E (see page 9), who have incomes above 250 percent of poverty. Within this overall limit, the state retains the discretion to establish different income levels for uninsured adults and children.

Each year, the Governor will recommend and the General Assembly will appropriate funds in an amount that will define the population to be served during the next fiscal year. Options that may be considered include:

- continue only to cover enrollees currently in the program;
- extend coverage during the enrollment period to new enrollees who meet the current eligibility categories;
- extend coverage and raise the eligibility standard to individuals at higher income levels (not to exceed 250 percent of poverty for Group C, see page 9);
- extend coverage to uninsured adults and children at different income levels, not to exceed 250 percent of poverty for either group;
- extend enrollment in TennCare Standard to persons in Group C or Group D (see page 9), but not to both groups; and

- lower the poverty levels and eliminate or scale back eligibility categories.

Therefore, the state proposes to establish the potential for two different levels of eligibility, one for those who at any point in time are already in the program and one for new enrollees in a given year. For example, if the program begins with a “currently eligible” standard of 100 percent of poverty for adults and the next year the state appropriates additional funds to raise the poverty level to 150 percent, the standard against which those currently in the program will be evaluated for continued eligibility will be 150 percent. If in the following year, the state opens eligibility to new adult members at the 100 percent of poverty level, current members will remain eligible up to 150 percent of poverty. Only if the state specifically lowers the threshold for current members will people lose their eligibility for the program. The TennCare Standard program, therefore, will allow for different income eligibility criteria for new enrollees and current enrollees in the modified waiver program.

“Medical eligibility” will be available to individuals who meet the state’s medical underwriting standards, regardless of income. The state will contract with a private sector insurance underwriter to determine medical eligibility using guidelines developed for the state. The state’s guidelines, prepared by the independent underwriter, will focus not simply on an individual having a particular disease but rather will look at a variety of health and risk factors to determine medical eligibility.

All applicants who apply for TennCare Standard in the “medically eligible” category will be required to pay a non-refundable application fee that will be used to fully offset the cost of administering the eligibility process. The fee is expected to be set at a range of somewhere between \$25-\$50.

All individuals enrolled in TennCare Standard with incomes above poverty will be required to pay premiums on a sliding scale basis. The premiums will be consistent with the current TennCare premium amounts and, during calendar year 2002, there will be no inflationary increase to the premium schedule (see Attachment C). Each subsequent year, the premiums will increase by an amount not to exceed the percentage of the aggregate budget increase necessary to sustain the managed care portion of the TennCare program (e.g. MCO, BHO, pharmacy and dental). Premiums will be increased each year at the same time the Department of Human Services updates the poverty level based on the federal government’s annual publication.

All persons enrolled in TennCare as of December 31, 2001, who are eligible for Medicare but not Medicaid (Group E, see page 9), will be allowed to remain in TennCare Standard, assuming that they continue to meet the “Uninsurability” criteria in effect at the time, but they will receive only pharmacy benefits. Those

who have incomes above poverty will have a separate premium obligation. The amount of these premiums will be set by the state.

Access to Group Health Insurance

TennCare is intended to offer coverage to Tennessee residents who are Medicaid eligible and, in certain cases, to people who are (1) uninsured or (2) uninsured and “medically eligible”. In keeping with federal regulations, Medicaid eligible individuals can have other insurance and still be eligible for TennCare. (Their private insurance is considered their primary insurance, with Medicaid/TennCare being secondary.) People who are uninsured or “medically eligible”, however, are by definition people who do not have access to group health insurance.

“Health insurance,” for purposes of the TennCare Program, is consistent with the HIPAA definition of “creditable coverage,” although TennCare will consider limited benefits policies, including those in which a beneficiary has used up all his benefits in a certain area, to qualify as insurance. People holding these kinds of policies would not meet the definition of “uninsured” and would therefore not be eligible for TennCare Standard.

TennCare considers insurance to include any hospital and medical expense incurred policy, nonprofit health care service plan, and health maintenance organization subscriber contracts. It does not include short term, fixed indemnity, long term care insurance, disability income contracts, credit insurance, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. For TennCare Standard enrollees with any of these types of policies, TennCare will be the payor of last resort.

“Group health insurance” is health insurance meeting the above definition, which is offered through an employer, a family member’s employer, a professional association, or a school. Both Medicare and TRICARE are available as a result of employment or a family member’s employment, so persons who can enroll in either of these forms of insurance are considered to have access to group health insurance. In the new program design, the only exception to this definition is made for those in Group E (see page 9), who are eligible only for pharmacy benefits under TennCare Standard.

Therefore, lack of access to group health insurance means that a person is unable to purchase--through his work, a family member’s work, a professional association or a school--insurance which meets the above definition. The fact that the insurance he or she is able to purchase meets the above definition but is not as comprehensive as TennCare or costs more than TennCare is not a

consideration for eligibility. For uninsured and “medically eligible” people, TennCare is intended to be a safety net, and not a choice among available insurance options. The intent of this policy is not to be punitive to those whose private policies are more expensive or contain fewer benefits than TennCare. Rather, the intent is to preserve TennCare for Medicaid eligibles and those who have no insurance at all or access to insurance.

Enrollment in most insurance plans is open only at certain times during the year. If a person could have enrolled in work-related insurance during an open enrollment period and simply chose not to enroll (or had the choice made for him or her by a family member), he or she would not be considered to lack access to insurance once the open enrollment period is closed. He/she would be considered to have access to insurance during the entire period he/she could have had coverage. For example, a person who has access to COBRA coverage for an 18-month period but who is allowed to enroll in COBRA only during the first 60 days of that 18-month period would be considered to have access to insurance for 18 months, even if he/she chose not to enroll during the first 60 days.

Enrollment and Disenrollment

With the exception of individuals qualifying for TennCare Standard at the end of their Medicaid eligibility, all **new** applicants for TennCare Standard must apply for eligibility during a designated open enrollment period. However, the state wishes to maintain the option of offering continuous enrollment to “medically eligible” individuals with incomes no greater than poverty. Individuals applying for coverage under TennCare Standard will have prospective enrollment only after the state verifies the potential enrollee’s income level, residency, and lack of insurance and collects premiums. The effective date of coverage for an individual determined eligible during an open enrollment period is anticipated to be 60 days after the end of the open enrollment period. The effective date of coverage for an individual determined eligible during a continuous enrollment period will be the day that the individual’s application is complete, assuming it is subsequently approved.

The state intends to collect data during the first six months of the full operation of the modified waiver to study the impact of this approach on the health status of potential enrollees and the operations of the TennCare program. After July, 2003, the state may seek to modify the initial approach to the enrollment of individuals into the TennCare Standard program.

During the enrollment process, individuals will be screened first for potential Medicaid eligibility and will be enrolled in the TennCare Medicaid program if eligible. If an individual is deemed ineligible for Medicaid, he or she will then be evaluated to determine if he or she is TennCare Standard eligible. Once qualified for TennCare Standard, participants will be deemed eligible for up to a

12-month period. However, individuals will be required to report any changes, such as a change in address, employment status or family composition, that could affect their ongoing eligibility and to pay any applicable premiums. TennCare will disenroll individuals who no longer qualify. Prior to the end of the enrollee's eligibility period, he or she must reapply in order to continue receiving coverage under TennCare Standard. As with a Medicaid model, TennCare Standard members will be responsible for reapplication.

Benefit Package

TennCare Standard will offer a package of benefits comparable to those offered to state employees through the HMO option. Enrollees with income levels above poverty will be assessed copays and premiums on a sliding scale. The copay and premium structure is similar to the current system with the exception of varied copays for pharmacy benefits based upon the distinction between brand name (\$15) and generic drugs (\$5). (See Attachment A.)

TennCare Standard enrollees will also receive a benefit package for behavioral health and substance abuse services. These benefits will be available to all participants to the extent they are medically necessary. (See Attachment B.)

The families of children enrolled in TennCare Standard will have the option of purchasing dental coverage for their children that is above and beyond that offered in TennCare Standard by paying the full cost of the coverage through the TennCare Dental Benefits Manager (DBM).

Currently eligible persons who have Medicare but not Medicaid (Group E, see page 9) will only receive pharmacy benefits.

The appeals process for all TennCare Standard enrollees will be similar to that available through commercial insurance plans.

Service Delivery (as described in Attachment D)

TennCare Standard physical health benefits will be delivered through the contracted MCOs. Behavioral health services will be delivered through a BHO and the behavioral pharmacy benefit will be provided through the state's pharmacy program. The pharmacy benefit for currently eligible persons who have Medicare but not Medicaid (Group E, see page 9) will be provided either through the state's MCO, TennCare Select, or its pharmacy program.

C. TENNCARE ASSIST

Once the modified TennCare Medicaid and TennCare Standard eligibility and benefit changes are fully in effect, the state intends to implement a program of assistance to low-income working people who have access to employer-sponsored health insurance. The program will be known as TennCare Assist.

TennCare Assist is designed to help low-income Tennesseans to purchase health insurance coverage through group health insurance programs. In the first year, estimated to be 2004, TennCare Assist benefits will be available, subject to state appropriations, to Tennessee residents below 250 percent of poverty who have access to insurance and who meet the criteria set out under “Eligibility” below.

At no time will the state provide TennCare Assist to individuals or families with incomes above 250 percent of poverty.

The purposes of the TennCare Assist program are to:

- make the expansion of health insurance coverage as sustainable as possible by leveraging private as well as public funds;
- allow families to obtain health insurance coverage as a unit;
- promote effective utilization of the health care system since such care is more frequently sought when whole families are covered as a unit;
- foster the long term viability of the private health insurance market; and
- promote the utilization of health coverage as an employee benefit.

Eligibility

The program will initially be available to Tennessee residents below 250 percent of poverty who meet the following criteria:

- they are employed;
- they have access to employer sponsored health insurance,
- their employer provides at least a standard HMO benefit with out-of-pocket expenditures that do not exceed \$2,000 for an individual or \$4,000 for a family; and
- their employer contributes at least 60 percent of the premium.

The employee must apply for and receive the full premium contribution available from the employer.

Qualified Health Insurance Program

The health insurance coverage offered by an employer or available to the self-employed must meet the standard for a qualified health insurance program. To

meet this standard, the coverage must offer a benefit package generally equivalent to a basic HMO package. The individual must have out-of-pocket expenses no greater than \$2000/individual and/or \$4000 family per year and the employer must contribute at least 60 percent of the cost of family coverage.

Cost of Comparable Coverage

The average cost of individual coverage in TennCare Standard will be the benchmark for individual coverage payment. The average cost of a family of four in TennCare Standard will be the benchmark for family coverage. In TennCare Assist, an average cost will be established for an adult and one child and an adult with multiple children, and those amounts will be the benchmarks for similar coverage in private plans.

The premium assistance paid by the state will be no more than 40 percent of the total cost of the coverage and no more than the cost of comparable coverage for enrollment in TennCare Standard.

Administration

TennCare Assist will be administered by a Third Party Administrator (TPA). Subsidies for premiums will be paid directly to the individual or family eligible for assistance.

Each participant will enroll in the health insurance program sponsored by his or her employer just as all other employees do. The employee will apply for (if necessary) and accept the maximum employer contribution. Enrollment in the employer-sponsored program will be verified by the state's TPA. The TPA will require documentation of the individual's or family's eligibility from the employer.

The TPA will gather the required information about the employer-sponsored or single-issue policy to assure that it provides the required coverage. The TPA will be required to build a database on various businesses' coverage and will use this database to update comparisons of comparable coverage. The TPA will, however, be required to verify monthly that the participant is still enrolled in the company-sponsored plan. The state will retain ownership of the database.

Participants in the program will be required to report any changes in income, employment status, or insurance status to the TPA. A change form will be included in each premium check for this purpose. The state will develop sanctions for individuals who do not comply with these reporting requirements.

D. OTHER PROGRAM DESIGN FEATURES

Special Hospital Payments

The state will continue to maintain a pool of dollars of \$100 million that will be used to make special payments to hospitals outside of the capitation payments to the TennCare MCOs. These payments will assist hospitals in covering a portion of the costs they incur for providing health care services to those who remain medically indigent. Nothing in this section related to special payments to hospitals will limit the state's ability to continue other special supplemental pool payments under the existing terms and conditions.

Graduate Medical Education

The state will make a payment of \$50 million for direct Graduate Medical Education, indexed by a recognized inflation factor. These funds will be made to the state's four medical schools and distributed by the medical schools to those hospitals and clinics that participate in the school's residency programs.

TennCare Advisory Board

The Governor will appoint an advisory board of 12-15 individuals comprised of health care and business leaders, providers, and consumers who will be charged with providing advice and direction to TennCare management on the managed care program. The TennCare Bureau and the Department of Commerce and Insurance shall present to the board every three months an update on MCO compliance with statutory and contractual requirements, including but not limited to prompt payment of claims and provider network adequacy (including arrangements to insure the provision of essential services).

Organizational Structure

The TennCare Bureau is a division of the Department of Finance and Administration. Under this modified program design, we intend to rename the division to show more clearly that it has responsibility for both components of the Title XIX program: TennCare, the managed care program; and other Title XIX programs including long-term care, HCBS waiver services, and Medicare cost sharing for identified groups.

Actuarial Soundness

The state will assess the rates paid to its contracted managed care organizations and behavioral health organizations each year. Included in the analysis will be a review of payments for hospital providers for similar services for comparable populations in other state Medicaid programs. The review will be considered in determining reasonable payment rates for hospital providers, including safety net hospitals providing essential and unduplicated services and sole community provider hospitals.

Enrollee Responsibility

Enrollees in the TennCare Standard program will be expected to assume personal responsibility for maintaining compliance with their premium obligations and for notifying the state of changes in their employment, family composition, or address. In addition, enrollees will not be automatically reenrolled into TennCare Standard if they do not reapply prior to the end of their eligibility period and get requalified for the program.

Enhanced Regulation of Managed Care Contractors

MCO oversight activities will be strengthened to insure that MCOs with possible difficulties in fulfilling their obligations to their enrollees and providers are identified early and assisted in resolving their difficulties. Plans will be monitored closely to assure network adequacy, as well as compliance with statutory and contractual requirements on matters such as timeliness of claims processing.

In the event that an existing plan expresses an interest in expanding its membership, TennCare will provide for independent evaluations of plan capabilities and capital requirements. No plans will be allowed to expand unless strict criteria are met.

The availability of TennCare Select as a backup plan gives the state additional flexibility in moving enrollees quickly, should a plan experience significant problems with quality of care, claims payment, and/or other key plan responsibilities.

Safety Net Providers

MCOs will be required to contract for safety net services as a mandatory element of an adequate MCO network.

III. Transition to the Modified TennCare Program

III. TRANSITION TO THE MODIFIED TENNCARE PROGRAM

In October of 2001, the state sought an extension of its current waiver in order to secure federal funding for the TennCare program during this period of transition to the modified program.

In anticipation of federal approval of the proposed modifications contained in this document, the state began a series of activities designed to assure the smoothest transition possible. The TennCare Bureau is developing a comprehensive Operational Protocol that will provide additional detail on how all aspects of the program will be run. This document, now required of all waiver states by the Center for Medicare and Medicaid Services (CMS), will become the basis for a thorough review of all existing TennCare rules relating to the managed care program so that all necessary rule changes can be drafted and the process of adoption begun as soon as the modifications are approved.

In addition, during the first half of calendar year 2002, the state will begin notifying the entire waiver population with information about the proposed new program including who will be eligible, what benefit changes will occur, and what new responsibilities enrollees will have. The state will also, to the extent possible, begin the process of classifying enrollees according to the new eligibility categories. The purpose of this extensive classification exercise will be to assure that all individuals are correctly identified as either belonging in one of the modified program's eligibility categories or as not being eligible for the modified program. Once these modifications are approved, all non-Medicaid enrollees will be evaluated to determine if they qualify. They will be informed of their status, their right to reapply for the program, and if applicable, the termination date, after which they will no longer be eligible for the program.

In July of 2002, assuming CMS has approved the waiver modifications, the new eligibility criteria will go into effect, and the state will begin disenrolling enrollees who are determined ineligible for the program under the new criteria. All enrollees who are disenrolled from the program pursuant to the new eligibility criteria will be given the right to notification and appeal. Enrollees who are determined to be eligible under the new criteria will continue with uninterrupted TennCare coverage, unless their circumstances change and make them ineligible for the program (e.g., they are incarcerated). If they are currently enrolled individuals in the demonstration population who are determined to be eligible for Medicaid, they will be moved to Medicaid immediately and any cost-sharing responsibilities they have had will end. The current TennCare benefit package will remain in place until December 31, 2002, at which time the benefits enrollees receive will be those of the plan in which they are enrolled.

During the fall of 2002 and the spring of 2003, the state anticipates conducting open enrollment periods for potential new eligibles. These open enrollment periods would be subject to appropriations from the General Assembly and availability of funds within the federal budget neutrality cap. So, for example, if the legislature appropriates sufficient state funding to open the program to uninsured persons with incomes below 250 percent of poverty (Group C, see page 9), people in this category of eligibility will be able to apply for TennCare Standard during the open enrollment period. The state may exercise the discretion to employ different income standards for uninsured adults and children. However, entry of new enrollees into the program and the beginning of benefits will not start until 60 days after the end of the open enrollment period. As stated in Chapter I, the state will retain the option of authorizing continuous enrollment for “medically eligible” individuals with incomes that do not exceed the poverty level.

By January 1, 2003, the modified TennCare program will be fully implemented for Medicaid and TennCare Standard. All MCOs will be required to offer both the Medicaid and Standard benefit packages. All new premium and copay requirements for enrollees will go into effect and the modified TennCare program will be fully in place. At that point, the state will finalize the design of the TennCare Assist portion of the program, perhaps beginning with a small group of willing employers to demonstrate the program design and to correct any features that do not appear to work properly.

During the next six months (January – July 2003), the enrollment procedures utilized for TennCare Standard will be evaluated and reported to the state and CMS. At that time, the state may wish to modify the annual enrollment design feature. See Attachment E.

IV. Waiver Requests

IV. WAIVER REQUESTS

TennCare has been operating since January 1994 pursuant to waivers of several statutory and regulatory requirements and a set of special terms and conditions as set forth in previous waiver approval documents. Continuation of those provisions is essential to the continued operation of the TennCare program. Based on those waivers and special terms and conditions, the state has built a financing system and program infrastructure that serves as the foundation for this worthwhile program. The success of the program to date, and the continued future success that the state anticipates, is dependent on those provisions. Accordingly, the state requests that the existing waivers (including authorizations to include expenditures that would not otherwise be includable) and the existing special terms and conditions be extended to the modified waiver.

In addition, the state requests several additional waivers/special terms and conditions to permit implementation of certain program changes or modifications previously described, or to take account of changes in federal law since the inception of the program.

I. Premium Assistance

Sections 1903 and 1905 provide that the federal government shall share in the cost of providing medical assistance to Medicaid eligible individuals. The definition of “medical assistance” at §1905(a) does not include payment of premiums to assist individuals in purchasing health insurance coverage. In addition, §1902(a)(32) prohibits payments under a State Plan to anyone other than the individual or provider of care or services. A modification of Tennessee’s demonstration program includes a program to assist low-income Tennesseans in purchasing health insurance through group insurance programs (TennCare Assist.) The program will be available to working adults with children and working adults without children based upon a family’s income as a percentage of poverty. Over time, the premium assistance program may be provided to individuals with family incomes up to 250 percent of poverty. It may also be extended to assist the unemployed in purchasing continued health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The state requests a waiver of §1902(a)(32) and §1905(a) to ensure that FFP is available at the appropriate federal matching rate for expenditures made to provide premium assistance under TennCare Assist.

II. Freedom of Choice:

II(a). Section 1932(a)(2) exempts certain populations, such as individuals with special needs, individuals dually eligible for Medicare and Medicaid, and Indians

(as defined by section 4(c) of the Indian Health Care Improvement Act) from mandatory managed care enrollment. The State of Tennessee seeks a waiver of Section 1932(a)(2) to allow the state to continue to cover these groups in a manner consistent with the demonstration program.

II(b). Section 1932(a)(3) requires states to offer a choice of at least two managed care entities. The State of Tennessee is requesting a waiver of this provision for two purposes.

First, the state seeks the authority to enroll its dually eligible population in one plan for all of their Medicaid needs, the state-owned, privately operated TennCare Select. The state seeks a waiver of §1932(a)(3), if necessary, to assure that it may provide services to the dually eligibles through the TennCare Select option. In addition, the state seeks authority to require that the Medicaid duals seek their prescription benefit from a single primary care provider or a specialist to whom the primary care provider has referred the individual.

Second, the state seeks the authority to enroll all TennCare eligibles in a single statewide Behavioral Health Organization for the purpose of receipt of behavioral health and substance abuse benefits. Past experience has led the state to believe that a single BHO is the most efficient model. This model will permit the state to focus on increased monitoring efforts to ensure that there is a sufficient choice of providers within the BHO's network.

III. Benefits

To the extent necessary, the state seeks a waiver of section 1902(a)(10)(B) and related regulations to permit it to offer different benefit packages to different categories of TennCare participants (e.g. TennCare Medicaid, TennCare Standard, and TennCare Assist) and within categories to the extent set forth in the program design.

IV. TennCare Assist

To the extent necessary, the state seeks a waiver of section 1932 to assure that the provisions of that section do not apply to the program of premium assistance for persons securing coverage from non-state-supported sources.

V. Grievance and Appeal Procedures

The state seeks a waiver of section 1932(b)(4) and implementing regulations with respect to participants in the TennCare Standard program (involving only expansion populations) to utilize grievance and appeal procedures established in

state law for commercial managed care organizations in lieu of the procedures applicable to Medicaid-eligible enrollees. To the extent that CMS believes that the state needs additional waivers to implement the proposed design, the state asks for these waivers.

V. Attachments

Attachment A

Summary of Physical Health Benefits TennCare Medicaid and TennCare Standard

Note: Copays referred to below are only for TennCare Standard enrollees whose family incomes are greater than 100 percent of poverty.

Benefit	Coverage under TennCare Medicaid	Coverage under TennCare Standard*
Inpatient hospital services	As medically necessary. Preadmission approval and concurrent reviews allowed. Age 21 and older: Rehabilitation hospital services may be covered when determined cost effective by the MCO. Under age 21: Rehabilitation hospital services covered under EPSDT.	As medically necessary. Preadmission approval and concurrent reviews allowed. Rehabilitation hospital services may be covered when determined cost effective by the MCO. <i>Copay: \$100 per admission.</i>
Outpatient hospital services	As medically necessary.	As medically necessary. <i>Copay: \$25 emergency room fee (waived if patient is admitted).</i>
Physician inpatient services	As medically necessary.	As medically necessary.
Physician outpatient services	As medically necessary.	As medically necessary. <i>Copay: \$10 for PCP services; \$15 for specialists' services; no charge for preventive services.</i>
Physical examinations and checkups	According to periodicity schedules to be published in the TennCare Handbook.	According to periodicity schedules to be published in the TennCare Handbook.
Lab and X-ray services	As medically necessary.	As medically necessary.
Hospice care	As medically necessary. Must be provided by	As medically necessary. Must be provided by

* Pharmacy services are the only covered benefit for TennCare Standard enrollees who also have Medicare.

Benefit	Coverage under TennCare Medicaid	Coverage under TennCare Standard*
	Medicare-certified hospice.	Medicare-certified hospice.
Vision services	Age 21 and older: Routine eye care not covered. Under age 21: Preventive, diagnostic, and treatment services (including eyeglasses), as medically necessary.	Age 21 and older: Routine eye care not covered. Under age 21: Annual eye exam covered, but other routine eye care not covered. <i>Copay: \$10 per visit.</i>
Dental services	Age 21 and older: Coverage limited to treatment of accidental injuries, neoplasms, infections, removal of impacted wisdom teeth. Under age 21: Preventive, diagnostic, and treatment services as medically necessary.	Age 21 and older: Coverage limited to treatment of accidental injuries, neoplasms, infections, removal of impacted wisdom teeth. Under age 21: Coverage limited to treatment of accidental injuries, neoplasms, infections, removal of impacted wisdom teeth. Additional benefits available for purchase through Dental Benefits Manager. <i>Copay: \$15 per visit.</i>
Home health care	Age 21 and older: As medically necessary, limited to 125 visits per enrollee per year. Under age 21: As medically necessary.	As medically necessary, limited to 125 visits per enrollee per year. <i>Copay: \$10 per visit.</i>
Pharmacy services	As medically necessary. DESI, LTE, and IRS drugs excluded.	As medically necessary. DESI, LTE, and IRS drugs excluded. <i>Copay: \$5 for generic drug or refill; \$15 for brand name or refill.</i>
Durable medical equipment	As medically necessary.	As described in the TennCare Handbook.
Medical supplies	As medically necessary.	As described in the TennCare Handbook.
Emergency air and ground ambulance	As medically necessary.	As medically necessary.

Benefit	Coverage under TennCare Medicaid	Coverage under TennCare Standard*
transportation		
Non-emergency transportation	As necessary to get the enrollee to and from covered services, for enrollees lacking access to transportation.	Not covered.
Renal dialysis services	As medically necessary.	As medically necessary.
EPSDT services	Age 21 and older: Not covered. Under age 21: Covered as medically necessary, except that screenings do not have to be medically necessary.	Not covered.
Private duty nursing	Age 21 and older: Not covered. Under age 21: Covered as medically necessary in accordance with EPSDT when prescribed by an attending physician for treatment and services rendered by an R.N. or a L.P.N. who is not an immediate relative.	Not covered.
Speech therapy	Age 21 and older: Covered as medically necessary to restore speech after a loss or impairment; must be provided by a Licensed Speech Therapist; patient must show continued medical progress. Under age 21: Covered as medically necessary in accordance with EPSDT.	Covered as short-term benefit per condition. Limited to 60 days from original treatment. <i>Copay: \$10 per visit.</i>
Organ transplant and donor organ procurement	Age 21 and older: Limited to coverage of transplants also covered by Medicare. Under age 21: Covered as medically necessary in accordance with EPSDT.	Limited to coverage of transplants also covered by Medicare for beneficiaries who have been enrolled in TennCare Standard for a minimum of six months. <i>Copay: See Inpatient Hospital.</i>
Reconstructive breast surgery	Covered in accordance with Tennessee Public Chapter	Covered in accordance with Tennessee Public Chapter

Benefit	Coverage under TennCare Medicaid	Coverage under TennCare Standard*
	452 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as any surgical procedures on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician.	452 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as any surgical procedures on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. <i>Copay: See Inpatient Hospital.</i>
Sitter services	Not covered.	Not covered.
Convalescent care services	Not covered.	Not covered.
Chiropractic services	Age 21 and older: Not covered. Under age 21: Covered as medically necessary through EPSDT.	Not covered.

Attachment B

Summary of Behavioral Health Benefits TennCare Medicaid and TennCare Standard

Note: Copays referred to below are only for TennCare Standard enrollees whose family incomes are greater than 100 percent of poverty.

Benefit	Coverage under TennCare Medicaid	Coverage under TennCare Standard*
Psychiatric inpatient hospital services	As medically necessary.	As medically necessary. <i>Copay: \$100 per admission.</i>
Psychiatric outpatient hospital services	As medically necessary.	As medically necessary. <i>Copay: \$25 emergency room fee (waived if patient is admitted).</i>
Psychiatric physician inpatient services	As medically necessary.	As medically necessary.
Psychiatric physician outpatient services	As medically necessary.	As medically necessary. <i>Copay: \$10 for Community Mental Health Agency services other than Mental Health Case Management; \$15 for all other psychiatric outpatient services.</i>
Inpatient and outpatient substance abuse benefits	Under age 21: As medically necessary, in accordance with EPSDT. Age 21 and older: As medically necessary, limited to 10 days detox, \$30,000 in lifetime benefits.	As medically necessary, limited to 10 days detox and \$30,000 in lifetime benefits.
Psychiatric pharmacy services	As medically necessary. DESI, LTE, and IRS drugs excluded.	As medically necessary. DESI, LTE, and IRS drugs excluded. <i>Copay: \$5 for generic drug or refill; \$15 for brand name or refill.</i>
Mental health case management	As medically necessary.	As medically necessary.

** Pharmacy services are the only covered benefit for TennCare Standard enrollees who also have Medicare.*

Benefit	Coverage under TennCare Medicaid	Coverage under TennCare Standard
24-hour psychiatric residential treatment	As medically necessary.	As medically necessary.
Emergency air and ground ambulance services	As medically necessary.	As medically necessary.
Non-emergency transportation	As necessary to get the enrollee to and from covered services, for enrollees lacking access to transportation.	Not covered.
Mental health crisis services	As medically necessary.	As medically necessary.

Attachment C
Monthly Premium & Income Table – Effective January 1, 2002*

Individual Premium	\$0	\$20.00	\$35.00	\$100.00	\$150.00
Family Premium	\$0	\$40.00	\$70.00	\$250.00	\$375.00
Percentage of Poverty	0% - 100%	101% - 149%	150% - 199%	200% - 249%	250% - 299%
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	\$0 - \$716	\$717 - \$1,073	\$1,074 - \$1,431	\$1,432 - \$1,789	\$1,790 - \$2,147
2	\$0 - \$968	\$969 - \$1,451	\$1,452 - \$1,935	\$1,936 - \$2,419	\$2,420 - \$2,903
3	\$0 - \$1,219	\$1,220 - \$1,828	\$1,829 - \$2,437	\$2,438 - \$3,047	\$3,048 - \$3,656
4	\$0 - \$1,471	\$1,472 - \$2,206	\$2,207 - \$2,941	\$2,942 - \$3,677	\$3,678 - \$4,412
5	\$0 - \$1,723	\$1,724 - \$2,584	\$2,585 - \$3,445	\$3,446 - \$4,307	\$4,308 - \$5,168
6	\$0 - \$1,974	\$1,975 - \$2,960	\$2,961 - \$3,947	\$3,948 - \$4,934	\$4,935 - \$5,921
7	\$0 - \$2,226	\$2,227 - \$3,338	\$3,339 - \$4,451	\$4,452 - \$5,566	\$5,565 - \$6,677
8	\$0 - \$2,478	\$2,479 - \$3,716	\$3,717 - \$4,955	\$4,956 - \$6,194	\$6,195 - \$7,433
9	\$0 - \$2,730	\$2,731 - \$4,094	\$4,095 - \$5,459	\$5,460 - \$6,824	\$6,825 - \$8,189
10	\$0 - \$2,982	\$2,983 - \$4,472	\$4,473 - \$5,963	\$5,964 - \$7,454	\$7,455 - \$8,945
For each family member over 10, add per month	\$0 - \$252	\$253 - \$378	\$379 - \$503	\$504 - \$629	\$630 - \$755
Individual Premium	\$200.00	\$250.00	\$350.00	\$450.00	\$550.00
Family Premium	\$500.00	\$625.00	\$875.00	\$1,125.00	\$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	\$2,148 - \$2,505	\$2,506 - \$2,683	\$2,864 - \$3,579	\$3,580 - \$4,295	\$4,296 – Over
2	\$2,904 - \$3,387	\$3,338 - \$3,871	\$3,872 - \$4,839	\$4,840 - \$5,807	\$5,808 – Over
3	\$3,657 - \$4,266	\$4,267 - \$4,875	\$4,876 - \$6,094	\$6,095 - \$7,313	\$7,314 – Over
4	\$4,413 - \$5,148	\$5,149 - \$5,883	\$5,884 - \$7,354	\$7,355 - \$8,825	\$8,826 – Over
5	\$5,169 - \$6,030	\$6,031 - \$6,891	\$6,892 - \$8,614	\$8,615 - \$10,337	\$10,338 – Over
6	\$5,922 - \$6,908	\$6,909 - \$7,895	\$7,896 - \$9,869	\$9,870 - \$11,843	\$11,844 – Over
7	\$6,678 - \$7,790	\$7,791 - \$8,903	\$8,904 - \$11,129	\$11,130 - \$13,355	\$13,356 – Over
8	\$7,434 - \$8,672	\$8,673 - \$9,911	\$9,912 - \$12,389	\$12,390 - \$14,867	\$14,868 – Over
9	\$8,190 - \$9,554	\$9,555 - \$10,919	\$10,920 - \$13,649	\$13,650 - \$16,379	\$16,380 – Over
10	\$8,946 - \$10,436	\$10,437 - \$11,927	\$11,928 - \$14,909	\$14,910 - \$17,891	\$17,892 – Over
For each family member over 10, add per month	\$756 - \$881	\$882 - \$1,007	\$1,008 - \$1,259	\$1,260 - \$1,511	\$1,512 – Over

* Separate premium structure to be established for TennCare Standard pharmacy benefit only.

Attachment D

Proposed Coverage Arrangements TennCare Medicaid and TennCare Standard

Benefits	Service Delivery Arrangements
Physical health benefits	Managed Care Organizations (MCOs), including TennCare Select
Behavioral health benefits	Behavioral Health Organizations (BHOs) (The state may use a single BHO for delivery of these benefits)
Dental benefits	Dental Benefits Manager (DBM)
Pharmacy benefits: <ul style="list-style-type: none"> Behavioral health drugs Drugs for Medicaid/Medicare dual eligibles (part of Group A, see page 9) Drugs for non-Medicaid eligible Medicare enrollees eligible for TennCare Standard (Group E, see page 9) <i>[this is the only TennCare benefit these enrollees receive]</i> All other drugs 	State's Pharmacy Program To be determined (MCOs, TennCare Select, or State's Pharmacy Program) To be determined (MCOs, TennCare Select, or State's Pharmacy Program) MCOs
Long term care	State
Home and Community Based Waiver Services (HCBS)	State
Medicare cost-sharing for Medicaid/Medicare dual eligibles	State

Attachment E

Proposed Timeline

NOTE: The following dates are proposed for planning purposes only. These dates are subject to change depending upon CMS approval, operational factors, etc.

January 2002	Extension of existing TennCare waiver begins
January-June 2002	State will begin notifying entire TennCare population about the proposed new program and will begin classifying enrollees according to new eligibility criteria
July 2002	New eligibility criteria go into effect; current enrollees who meet the new eligibility criteria will remain on TennCare State will begin disenrolling current TennCare members who do not meet new eligibility criteria
Fall 2002	Subject to legislative appropriation, state will conduct an open enrollment period for potential new eligibles, using income thresholds for TennCare Standard approved by the General Assembly in its spring 2002 session; a continuous open enrollment period may also be authorized for subgroups of the demonstration populations, subject to availability of funds
January 2003	Modified TennCare Medicaid program begins TennCare Standard begins Coverage begins for new TennCare members identified during the fall open enrollment period Benefit changes go into effect
Spring 2003	Subject to appropriation, state will conduct an open enrollment period for potential new eligibles, using income thresholds for TennCare Standard approved by the General Assembly in its spring 2002 session; a continuous open enrollment period may also be authorized for certain subgroups of the demonstration population, subject to availability of funds
January-June 2003	Enrollment procedure used for TennCare Standard to be evaluated

Fall 2003

Subject to appropriation, state will conduct an open enrollment period for potential new eligibles, using income thresholds for TennCare Standard and TennCare Assist approved by the General Assembly in its spring 2003 session; a continuous open enrollment period may also be authorized for certain subgroups of the demonstration population, subject to availability of funds

January 2004

TennCare Assist begins

Coverage begins for new TennCare members identified during the fall open enrollment period

